

COMMUNITY HEALTH DEVELOPMENT, INC.

Consent for Treatment

Name of Patient: _____ **Date of Birth:** ____/____/____

Name of person giving consent if different from Patient:

[Print Name]: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other: _____

I hereby and voluntarily consent to authorize the agency's healthcare providers to provide health care services to me or the above minor at the agency's service locations. The health care services may include, without limitation routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and health and/or dental treatment; routine laboratory procedures and tests, which may include testing for Human Immunodeficiency Virus; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the agency's healthcare providers, unless I tell my provider I refuse treatment or services. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I may be required to sign a separate parental consent form in order for my child to receive family planning services. I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me or my child and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as the above named patient is a patient of the agency, until I withdraw consent in writing, or until the agency changes its services and asks me to complete a new consent form, or my child turns 18 and must consent for services on his or her own behalf.

☐ I hereby delegate authority to consent to treatment for the above minor to

[Print name]: _____

for the period of ____/____/____ through ____/____/____ .

Consent Provisions

My signature on page 2 of this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that midlevel providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such.
5. I hereby voluntarily give my consent to Treatment at the Agency.
6. I choose _____ as my Primary Care Provider, I understand I can change my PCP at any time.

[Signature of Patient or Legal Representative]

Print Name: _____

Date/Time: _____

If the signature above is other than the Patient, indicate

relationship: _____

[Signature of Witness to signature above]

Print Name of Witness: _____

Date/Time: _____

Interpreter/Translator if used:

I have accurately and completely read/translated the foregoing document to: [Insert the Patient's or Patient's Legal Representative's name] _____
in [Language) _____, the Patient's or Patient's Legal Representative's primary language. She/he understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing this document in my presence.

Interpreted/Translated By: _____

[Signature of Interpreter/Translator]

Print Name of Interpreter/Translator: _____

Date/Time: _____